STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/15/12 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	determined to be of Type II (111) construction and was fully sprinklered except as noted at K-56. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and hard wired smoke detectors in resident rooms 301 to 306 and 324 to 326. The remaining resident rooms had battery operated smoke detectors. The facility has a capacity of 100 and had a census of 57 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage. The facility was found in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered, except the small enclosed area where the laundry chute is located on the second and third floors and the computer room closet in the conference room. All areas providing facility services were sprinklered, except two detached sheds used for storage of maintenance parts and			

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	equipment and Christmas decorations. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/21/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 second floor storage rooms with combustibles, measuring over 50 square feet in size was provided with a self closing device. This deficient practice was not in a resident care area but could affect staff. Findings include: Based on observation with the Maintenance Director on 11/15/12 at 2:03 p.m., the corridor door to resident room 224, measuring 286 square feet in size, lacked a self closing device. The room was currently being used as a storage room containing	K0029	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Autumn Ridge Rehabilitation Centre desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on December 7, 2012 -	12/07/2012

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	combustible storage such as 20 plastic totes of medical records and two cardboard boxes of activity supplies. This was confirmed by the Maintenance Director at the time of observation. 3.1-19(b)		What corrective action will be done by the facility? A facility inspection was implemented and no further deficiencies were noted. A self-closing device was added to the door to resident room 224 on November 26, 2012. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were affected. What measures will be put into place to ensure this practice does not recur? The Maintenance Director or designee will make routine inspection audits (see attachment A) one time each week for two weeks then monthly for two months then quarterly thereafter of all rooms in the facility to ensure the	

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			presence of door closures on doors to which residents have customary access and doors to storage rooms containing combustibles to ensure compliance. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Supervisor or designee will report finding to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any non-compliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/12	

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K0046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient	K0046	What corrective action will be done by the facility? A preventative maintenance audit tool has been initiated (see attachment B) to ensure emergency light fixtures of at least 1.5 hour duration are tested monthly and annually. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents have been affected; all residents have the potential to have been affected. A written record of visual inspections and tests was put into the facility preventative maintenance-monitoring log. What measures will be put into place to ensure this practice does not recur?	12/07/2012

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	practice could affect all occupants. Findings include: Based on an observation with the Maintenance Director on 11/15/12 at 3:15 p.m., a battery operated emergency task light was observed at the emergency generator. Based on an interview with the Maintenance Director during record review at 12:53 p.m., there was no written record of a monthly function test or an annual test for the battery operated emergency task light available for review. 3.1-19(b)		The Maintenance Director or designee will complete preventative maintenance audit tool (see attachment B) completing a functional test on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted to the battery powered emergency lighting system for not less that 1.5 hours duration. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Supervisor or designee will provide the results of each audit and review the preventative maintenance log with the Executive Director or designee upon completion. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the	

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			event any non-compliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/12	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 2 of 2 small enclosures where the laundry chute is located on the second and third floors and 1 of 1 conference room computer room closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect all 23 second floor residents, 15 third floor residents and any residents in the conference room with a seating capacity of 10 residents. Findings include:	K0056	What corrective action will be done by the facility? Sprinkler heads have been installed to the computer storage room closet and both the second and third floor laundry chute closets. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? A facility inspection was implemented and no further deficiencies were noted. Sprinkler heads have been outfitted to the computer storage room closet and both the second and third floor laundry chute closets.	12/07/2012

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	Based on an observations with the Maintenance Director on 11/15/12 from 1:31 p.m. to 2:44 p.m., the second and third floor small enclosures where the laundry chute is located and the conference room computer room closet lacked sprinkler coverage. This was acknowledged by the Maintenance Director at the time of observations. 3.1-19(b) 3.1-19(ff)		What measures will be put into place to ensure this practice does not recur? The Maintenance Supervisor of designee will make routine inspection audits (see attachment C) one time each week for two weeks then monthly for two months then quarterly thereafter to ensure compliance is met. What measures will be put into place to ensure this practice does not recur? The Maintenance Supervisor or designee will report finding to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any non-compliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/12	

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K0062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure cubicle curtains installed in 1 of 1 third floor shower rooms were in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Because of the lack of cubicle curtain and sprinkler location coordination which may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler, this deficient practice could affect three residents in the third floor shower room. Findings include: Based on observation with the Maintenance Director on 11/15/12 at 1:24 p.m., two of three shower curtains in the third floor shower room lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector. This was acknowledged by the Maintenance Director at the	K0062	What corrective action will be done by the facility? The shower curtains in the third floor shower room have been replace with shower curtains with a ½ inch diagonal mesh top panel that extends 18 inches below the sprinkler deflector. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were affected. Three residents had the potential to have been affected by this practice. The shower curtains in the third floor shower room were replaced with shower curtains with a ½ inch diagonal mesh top panel that extends 18 inches below the sprinkler deflector disallowing the shower curtain to obstruct the sprinkler spray. What measures will be put	12/07/2012

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	time of observation. 3.1-19(b)		into place to ensure this practice does not recur? The Maintenance Supervisor of designee will make routine inspection audits (see attachment D) of facility one time each week for two weeks then monthly for two months then quarterly thereafter to ensure compliance is met. What measures will be put into place to ensure this practice does not recur? The Maintenance Supervisor or designee will report finding to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any non-compliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/12	

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 1. Based on observation and interview, the facility failed to ensure all oxygen cylinders were properly restrained in 2 of 2 oxygen storage/transfilling rooms. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b)27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect 15 third floor residents. The second floor oxygen storage room was located in a closed unit but this deficient practice could affect any number of staff. Findings include: Based on an observations with the	K0076	What corrective action will be done by the facility? All "E" and "H" cylinder compressed oxygen tanks have been removed from the facility. All combustible materials have been removed from the oxygen storage rooms. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents have been affected; fifteen residents had the potential to have been affected. All "E" and "H" cylinder compressed oxygen tanks have been removed from the facility. All combustible materials have been removed from the oxygen storage rooms.	12/07/2012

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	Maintenance Director on 11/15/12 from 1:05 p.m. to 1:50 p.m., there was an unsupported "E" cylinder of compressed oxygen in the third floor oxygen storage/transfilling room and four "H" cylinders of compressed oxygen unsupported in the second floor oxygen storage/transfilling room. This was acknowledged by the Maintenance Director at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure combustible materials were separated from oxygen storage equipment in 1 of 2 oxygen storage areas. NFPA 99, the Standard for Health Care Facilities, Section 8-3.1.11.2(c)2 requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet in a fully sprinklered building. This deficient practice affects residents 15 third floor residents. Findings include:		What measures will be put into place to ensure this practice does not recur? The Maintenance Supervisor of designee will make routine inspection audits (see attachment E) of facility one time each week for two weeks then monthly for two months then quarterly thereafter to ensure compliance is met. What measures will be put into place to ensure this practice does not recur? The Maintenance Supervisor or designee will report finding to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any non-compliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/2012	

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	Based on an observation with the Maintenance Director on 11/15/12 at 1:06 p.m., combustible material such as cardboard boxes were stored within three feet of stationary liquid oxygen containers and an "E" cylinder of compressed oxygen in the third floor oxygen storage room. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed ensure 1 of 1 emergency generators met the requirements for transferring power from the main source to the emergency generator. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants Findings include: Based on review of the "Weekly Exercise/Monthly Load Test Log" with the Maintenance Director on 11/15/12 at 12:28 p.m., the monthly load test record indicated the transfer of power from the main source to the emergency generator took from 22 to 28	K0144	What corrective action will be done by the facility? The process for which the Maintenance Supervisor utilizes to transfer power from the main source to the emergency generator has been clarified and now meets the requirement. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents have been affected; all residents had the potential to have been affected The process for which the Maintenance Supervisor utilizes to transfer power from the main source to the emergency generator has been clarified and now meets the requirement. What measures will be put into place to ensure this practice does not recur? The Maintenance Director or designee will complete preventative maintenance	12/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	11/15/2012

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	seconds for the previous 10 months of 2012. This was confirmed by the Maintenance Director at the time of record review. 3.1-19(b)		audit tool (see attachment G) completing a functional test transferring power from the main source to the emergency system within 10 seconds one time each week for two weeks then monthly for two months then quarterly thereafter. What measures will be put into place to ensure this practice does not recur? The Maintenance Supervisor or designee will report finding to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any non-compliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/12 **NFPA 101 LIFE SAFETY CODE** **Name :** _____ ____ **Date:** _____	

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			K144 **Yes** **No** COMPLETE FUNCTIONAL TEST TRANSFERRING POWER FROM THE MAIN SOURCE TO THE GENERATOR WITHIN 10 SECONDS COMMENTS:	

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			Reviewed by Executive Director: _____ _____ Signature/Date Follow up required:	